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☐ FSA ☐ DCA ☐ LFSA ☐ HRA	☐ Yes ☐ No

Total Reimbursement Requested *(Required)* =

Dependent Name *(First, Last)*	Dependent Birth Date *(mm/dd/yyyy)*	Dependent SSN	Service Type *(Select one.)*
			☐ Child Care ☐ Adult Care [2]

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